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"02" Combats Missed Doses

We have seen a rash of incidents reporting missed doses of non-pouch medications. This is alarming, as drugs such as antibiotics, Paxlovid®, and urgent BP meds are amongst those not being given reliably.

No doubt, staffing challenges and the introduction of new nurses are in part responsible for the missed doses. Still, it is necessary to take action to try to mitigate this problem. After a bit of brainstorming, we've come up with a partial solution.

To separate antibiotics, antivirals, and other mid-cycle medications from their pouched brethren, we are assigning them a distinctive time in eMAR. That time will end in "02". If one of these meds is to be given with the AM pass, the eMAR entry will now show 0802 rather than 0800. A noon pass will display 1202 (1132 in some homes), etc. This will help these drugs stand out when displayed with multiple pouch medications listed at standard default times. We have begun this process already. We are adding other cues, such as "Vial" or "Box". We will see if the expected reduction in incidents is realized and also review audits from our QA nurse to see how effective this measure is.

Apixaban Fails to Surprise – in a Good Way

Several studies have shown that apixaban causes less GI (and perhaps other) bleeds than its two main rivals, rivaroxaban (Xarelto®) and dabigatran (Pradaxa®). There have been questions about the validity of these studies, however, with critics claiming differences in patient groups or that dosing issues were responsible for the disparities.

A massive study that gives further clarity on this topic has just been released. Though it was an observational study the scope was very large. It followed over 525,000 patients with a new NOAC (novel oral anticoagulant) Rx after an initial atrial fib diagnosis. Databases from four different countries, France, Germany, the UK, and the US were accessed. That variety added to the strength of the study. Of relevance to us, there were also subgroup analyses of patients 80+ years of age and those with CKD. The results in these groups were similar to those of the broader database.

Apixaban, used by 53.4% of patients, was compared to the three other commonly used NOACs. Patients were followed for 1.4 to 4.4 years after treatment initiation. All NOACs showed similar activity in the prevention of ischemic stroke and systemic embolism, and there were no significant differences in cerebral hemorrhage (of interest) or all-cause mortality.

Apixaban caused fewer GI bleeds than the other NOACs, including the somewhat newer drug, edoxaban (seldom seen in large comparative studies). The relative risk of apixaban vs the others was 72% vs rivaroxaban, 77% vs edoxaban, and 81% vs dabigatran. This further supports the popularity of apixaban relative to its peers. A proper, randomized trial, COBRRA, is underway comparing apixaban 5mg BID to rivaroxaban 20mg daily. That should give a definitive answer to these drugs' relative safety and efficacy.

Tamiflu Dosing Revisions

Public Health has changed the guidelines related to Tamiflu® for staff and some residents since our last outbreaks three years ago. All staff with resident contact must take Tamiflu® throughout the outbreak, even when they are not in the facility. Tamiflu® upon entry had been deemed sufficient in the past. Swab-positive residents who are symptomatic for over 48 hours and are improving do not receive Tamiflu®.

Prepared by Randy Goodman
Board Certified Geriatric Pharmacist